Report No. D-2009-037 December 31, 2008

Inspector General
United States
Department of Defense

TRICARE Controls Over Claims Prepared by Third-Party Billing Agencies

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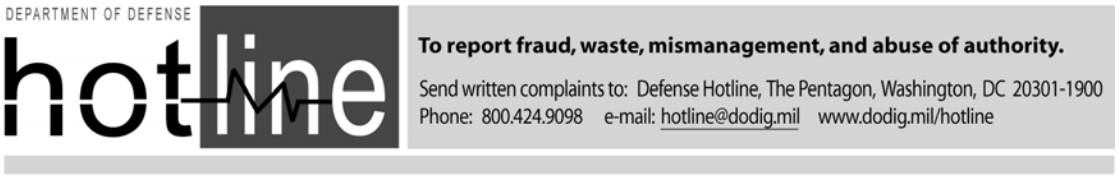

Acronyms and Abbreviations

CMS	Centers for Medicare and Medicaid Services
GAO	Government Accountability Office
HHS	Department of Health and Human Services
OIG	Office of Inspector General
TMA	TRICARE Management Activity

INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
400 ARMY NAVY DRIVE
ARLINGTON, VIRGINIA 22202-4704

December 31, 2008

MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE
(HEALTH AFFAIRS)

SUBJECT: TRICARE Controls Over Claims Prepared by Third-Party Billing Agencies
(Report No. D-2009-037)

We are providing this report for your information and use. We considered management comments on a draft of the report when preparing the final report.

Comments on the draft of this report conformed to the requirements of DoD Directive 7650.3 and left no unresolved issues. Therefore, no additional comments are required.

We appreciate the courtesies extended to the staff. Please direct questions to me at (703) 604-8866 (DSN 664-8866). If you desire, we will provide a formal briefing on the results.

Joseph R. Oliva, CPA
Assistant Inspector General
Readiness, Operations, and Support

Report No. D-2009-037 (Project No. D2008-D000LF-0100.000)
December 31, 2008

Results in Brief: TRICARE Controls Over Claims Prepared by Third-Party Billing Agencies

What We Did

In 2006, we reported on controls over TRICARE payments made to overseas health care providers. We identified a billing agency in the Philippines that submitted false claims and was eventually convicted by the U.S. Attorney's Office for receiving fraudulent payments totaling about $100 million.

We performed this audit to determine whether similar weaknesses existed within TRICARE in the United States. Centers for Medicare and Medicaid and Department of Health and Human Services have identified problems with billing agencies in the United States and have developed regulations to deter future fraud by these agencies. The objective of the audit was to evaluate the adequacy of TRICARE controls over payments for health care claims prepared by billing agencies for care provided in the United States.

What We Found

The TRICARE Management Activity needs to improve controls over payments for health care claims prepared by billing agencies for care provided in the United States. Contrary to the Federal regulations and the TRICARE Operations Manual, the TRICARE Management Activity sent payments to billing agencies rather than to providers and also paid claims prepared by billing agencies that were excluded by the Department of Health and Human Services from participating in Federal health care programs.

The TRICARE Management Activity made these payments because it did not identify relationships between providers and billing agencies, and when sending payments, it used the billing agency's address instead of the provider's address. Further, TRICARE Management Activity officials believed they lack the authority to exclude billing agencies that are involved in preparing or submitting improper health care claims.

What We Recommend

We recommend that the Director, TRICARE Management Activity strengthen controls by:

- identifying relationships between providers and billing agencies,
- ensuring that provider addresses are not those of billing agencies, and
- initiating action to obtain the statutory or regulatory authority to sanction billing agencies or any entities that prepare or submit improper health care claims to the TRICARE contractors.

Implementing these controls should reduce the likelihood of improper payments.

Client Comments and Our Response

The Assistant Secretary of Defense (Health Affairs) comments were responsive to the recommendations and no further comments are required. See recommendations table on page ii.

Recommendations Table

Client	Recommendations Requiring Comment	No Additional Comments Required
Director, TRICARE Management Activity		1., 2., 3.

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Introduction

Background

The TRICARE Management Activity (TMA) is responsible for managing TRICARE, the DoD health care program for active duty and retired service members and their dependents. TMA oversees the contractors responsible for delivering benefits throughout three regions (North, South, and West) within the United States and establishes guidelines for claims processing. As of January 2008, these TRICARE contractors paid about $7.2 billion in FY 2007 for care provided within the United States.

Health care providers may submit claims directly to a TRICARE contractor or through other organizations, such as third-party billing agencies or clearinghouses. Providers using billing agencies must furnish patient and service information to the billing agencies, who then submit claims directly to the TRICARE contractors or through a clearinghouse for processing. Clearinghouses electronically format the claims prepared by providers or billing agencies and submit them to the TRICARE contractors for payment. According to the Healthcare Billing & Management Association, billing agencies process more than 200 million claims for about $18 billion a year.[1]

Federal Concerns About Billing Agencies

In February 2006, DoD Inspector General Report No. D-2006-051, "TRICARE Overseas Controls Over Third Party Billing Agencies and Supplemental Health Insurance Plans," reported on health care claim payments to billing agencies for care provided overseas. The report showed that a billing agency in the Philippines submitted inflated charges and received payment directly from TRICARE. This billing agency was eventually convicted by the U.S. Attorney's Office for receiving fraudulent payments totaling about $100 million. To reduce the likelihood of improper payments for claims submitted by billing agencies for care provided overseas, we recommended that TMA stop sending payments to billing agencies. These billing improprieties led us to question whether similar activities were occurring within the United States.

The Department of Health and Human Services (HHS) works closely with State and local governments to protect the health of all Americans and provide essential human services through Medicare. The Centers for Medicare and Medicaid Services (CMS)[2] is responsible for managing Medicare. More and more, providers are relying on billing agencies to process their claims in accordance with Federal and State laws. As a result, the HHS Office of Inspector General (OIG) has issued guidance to assist billing agencies in developing internal controls that adhere to existing claims processing and reimbursement laws.

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[1] Healthcare Billing & Management Association is a trade association representing third-party billing agencies.

[2] Formerly the Health Care Financing Administration.

In testimony, an HHS OIG official stated "the problems associated with dishonest third-party billing companies are as old as the Medicare program itself."[3] Additionally, a CMS official testified that CMS' ability to detect such abuses was limited because it did not have a "direct business relationship" with billing agencies.[4] According to Government Accountability Office (GAO), identifying fraud committed by billing agencies is like detecting needles in a haystack; however, if program officials can link providers to problematic billing agencies, this will give them a magnet to detect the needles.[5]

In an attempt to mitigate this problem, CMS issued a new enrollment form in May 1996 that required detailed information from all providers regarding which billing agency they use, if any (see Appendix B), and CMS stores this information electronically. According to a CMS official, CMS requires all providers to revalidate their enrollment information periodically and to notify the claims contractor within 30 days of any changes in enrollment information.

An HHS OIG official testified that sending payments to billing agencies could result in undetected fraudulent claims for services billed but not rendered because the provider would be unaware of the false claims being submitted.[3] The volume of claims prepared by billing agencies and the amount of beneficiary and provider information they maintain could allow them to bill for improper charges. Over the years, HHS OIG and DoD OIG officials identified several cases of billing agency fraud or abuse that impacted Medicare and TRICARE. See Appendix C for a listing and description of some of those cases.

Standardization of TRICARE and Medicare Claims

The National Defense Authorization Act for Fiscal Year 2007 (Defense Authorization Act) requires standardization of claims processing between TRICARE and Medicare.[6] The Defense Authorization Act requires the Secretary of Defense to submit an annual report listing the differences found between the two programs and justifications for each. According to the Secretary's October 2007 report, DoD performed a comprehensive assessment of the TRICARE claims processing requirements from the point at which services were rendered to the time the claim was paid or denied and compared each stage to the claims processing requirements of Medicare. The report identified seven differences in claims processing, none of which were related to billing agencies.

TMA officials believe the Defense Authorization Act is not applicable because identifying and paying billing agencies is not a claims processing issue. In our opinion, however, this falls within the scope of claims processing as identified in DoD's comprehensive assessment. Moreover, CMS includes guidance on paying billing agencies in its "Medicare Claims Processing Manual."

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[3] Testimony before the House Committee on Commerce, Subcommittee on Oversight and Investigations, April 6, 2000 Statement of Lewis Morris, HHS Assistant Inspector General for Legal Affairs.
[4] Testimony April 6, 2000, Statement of Penny Thompson, CMS Program Integrity Director.
[5] GAO/T-HEHS-00-93.
[6] Section 731, "Standardization of Claims Processing Under TRICARE Program and Medicare Program."

Identification of Billing Agencies

Throughout the audit, we attempted to identify billing agency-related claims, but TMA does not maintain such data. As a result, we were unable to determine the total amount of TRICARE claims prepared by billing agencies. Without this information, we could not identify potentially fraudulent billing patterns involving billing agencies. However, through contacts we made with Federal and private health care organizations, we were able to identify several billing agencies that were involved in submitting TRICARE claims. We identified improper claims for a provider that used a billing agency and issued a criminal referral to the Defense Criminal Investigative Service regarding the improper claims.

Objective

The objective of the audit was to evaluate the adequacy of TRICARE controls over payments for health care claims prepared by billing agencies for care provided in the United States. See Appendix A for a discussion of the scope and methodology, review of internal controls, and prior coverage related to the objective.

Review of Internal Controls

Our audit showed that TMA needs to strengthen its internal controls over claims prepared by billing agencies. Because we could not quantify the total amount of TRICARE claims prepared by billing agencies, we were unable to determine whether the internal control weakness was material, as defined by DoD Instruction 5010.40, "Managers' Internal Control (MIC) Program Procedures," January 4, 2006. See the Finding for an explanation of the internal control weakness identified by this audit. Implementing Recommendations 1., 2., and 3. will improve controls over claims prepared by billing agencies. We will provide a copy of this report to the senior TMA official responsible for internal controls in TRICARE.

Finding. Controls Over Payments for Claims Prepared by Billing Agencies

The TMA needs to improve controls over payments for health care claims prepared by billing agencies for care provided in the United States. TMA was sending payments to billing agencies and paying claims prepared by billing agencies that HHS had excluded. TMA could strengthen controls by identifying the relationships between providers and billing agencies and by ensuring that a billing agency address is not shown as a provider address. Further, TMA should initiate action to modify Federal regulations to give it the authority to exclude billing agencies abusing or committing fraud against TRICARE. Implementing additional controls over payments for health care claims prepared by billing agencies should help reduce the likelihood of improper payments.

Payments for Billing Agency Claims

Contrary to Federal regulations and the TRICARE Operations Manual, TMA sent payments to billing agencies.[7,8] Additionally, TMA paid claims prepared by billing agencies that HHS had excluded from participating in a Federal health care program.

Payments Made to Billing Agencies

TMA sent payments to billing agencies. Federal regulations require that payments go to the beneficiary or to the provider. Further, the TRICARE Operations Manual states that payments should be made to the providers even if they use a billing agency. Similarly, CMS requires that Medicare payments go to providers. TMA officials believed that the claims processing contractors were not sending payments to billing agencies. We obtained billing agency mailing address information from private insurance contacts, the Internet, and claims data. Using the mailing address information, we identified at least $2.1 million that TMA sent to three billing agencies in FYs 2006 and 2007, as shown in Table 1.

Table 1. TRICARE Payments Sent to Three Selected Billing Agencies

Billing Agency	No. of Claims	Amount Paid
A	7,215	$1,374,147.36
B	4,382	562,675.93
C	1,650	206,639.26
Total	**13,247**	**$2,143,462.55**

Note: Details will be provided to TMA under separate cover.

We believe it is likely that TMA sent payments to other billing agencies as well, but we were unable to quantify the magnitude of these payments because TMA does not gather billing agency information and cannot identify which claims were prepared by billing

[7] 32 C.F.R. Section 199.7.
[8] TRICARE Operations Manual 6010.51-M, August 2002.

agencies. Sending payments to billing agencies may increase the risk to TMA that billing agencies are submitting fraudulent claims without the provider's knowledge.

Payments for Claims Prepared by HHS-Excluded Billing Agencies

TMA paid claims prepared by billing agencies that HHS had excluded. HHS has the authority to exclude individuals and entities from participation in any Federal health care program.[9] HHS maintains information in a database called the "List of Excluded Individuals/Entities," which is available to the public, providers, beneficiaries, and other agencies. TMA obtains a copy of this list monthly and forwards it to the TRICARE contractors for file updates and implementation. Because TMA did not verify provider versus billing agency addresses and because the TRICARE Purchased Care Detail Information System does not identify billing agencies or the claims they prepare, TMA could not identify the HHS-excluded billing agencies within its databases and prevent payments to these entities, as required by law.[9]

We searched the HHS Exclusion Program Web site and found 101 excluded billing agencies as of January 2008. We matched the mailing addresses of the HHS-excluded billing agencies to the TRICARE claims database and saw that payments were sent to the addresses of three billing agencies, totaling about $20,000, after the HHS exclusion date. Additionally, TMA sent $95,000 to an address similar to that of another billing agency. However, we were unable to determine whether the payments actually went to the billing agency because, for those claims, the database did not include a suite number and the building had other occupants, possibly including providers. Because TMA is unable to identify billing agencies and the claims they prepare, it may have sent payments to additional excluded agencies. HHS continues to identify problems with billing agencies as evidenced by the fact that the number of billing agency exclusions has risen, and as of July 2008, there were 113 billing agencies on the HHS exclusion list.

Identification of Billing Agencies

TMA could improve its internal controls by identifying provider and billing agency relationships and ensuring that billing agency addresses are not shown as provider addresses. Implementing these internal controls should help ensure that TMA does not send claim payments to billing agencies or pay claims prepared by HHS-excluded billing agencies. In an effort to identify provider and billing agency relationships, CMS officials collect billing agency name and address information during the provider certification process using CMS Form 855, "Medicare Enrollment Application" (see Appendix B). Although the Defense Authorization Act requires standardization of claims processing between TRICARE and Medicare, TMA does not collect this information.

Provider-Billing Agency Relationships

Similar to CMS procedures, TMA could improve controls by gathering billing agency information during the provider certification and credentialing process. Any entity that

[9] Section 1128 of the Social Security Act (42 U.S.C. 1320a-7).

provides health care services to TRICARE beneficiaries must be certified by the State. TMA accepts two groups of providers: nonnetwork and network. Nonnetwork providers must pass the State certification process and must complete a provider application. Network providers, as part of the TRICARE credentialing process, must file a provider agreement with the TRICARE contractor. The agreement requires the provider to follow certain terms, such as agreeing to negotiated reimbursement rates. Both nonnetwork applications and network agreements require that the provider list its physical address and its billing address.

Provider Addresses

TMA could ensure that billing agency addresses are not shown as provider addresses by verifying the information captured in the TRICARE Purchased Care Detail Information System. This information shows a physical address and a billing (mailing) address for each provider, but TMA officials could not determine whether the addresses belonged to the provider or a billing agency. For one of the billing agencies shown in Table 1, we identified 186 provider IDs in the TRICARE database that listed a billing agency address as the provider's billing address. Further, for the 186 provider IDs, 93 also had the billing agency listed as the provider's physical address. We further determined that 8 of the 93 provider IDs were for surgery centers or clinics that have known physical addresses.

According to TMA guidance and contractor officials, it is acceptable for some providers, such as anesthesiologists, to use the billing agency address as their physical and billing address because the providers work in numerous facilities and may not have an office. Regardless of the type of provider, we believe TMA should not use a billing agency address for either the provider's physical location or billing address. The TRICARE Systems Manual states that anesthesiologists, radiologists, and pathologists may use a street address or a P.O. Box as their physical address, but there is no mention of using a billing agency address.[10]

Impact of Identifying Relationships and Addresses

Identifying provider and billing agency relationships, and ensuring that a billing agency address is not shown as a provider address, should help ensure that payments are not sent to billing agencies and payments are not made for claims prepared by HHS-excluded billing agencies. Identifying the relationships should also allow TMA to identify aberrant billing patterns involving billing agencies.

We learned that a CMS contractor for program integrity formed a billing agency workgroup, which consisted of representatives from CMS as well as CMS contractors, to learn more about possible fraud in the electronic environment. This CMS contractor created a database linking providers that had aberrant billing patterns to billing agencies, thereby identifying 25 questionable billing agencies for which each had at least 70 percent of its providers on fraud watch. By linking providers with the suspect billing

[10] TRICARE Systems Manual 7950-1M, August 2002.

agencies, the CMS contractor could determine the extent of possible improper billings and identify other providers whose claims should be monitored.

From its efforts, the billing agency workgroup identified fraudulent patterns, including relationships between suspect providers and organizations providing billing services (billing agencies and clearinghouses). The workgroup also identified that the providers and billing agencies were submitting duplicate claims and using provider and beneficiary information to submit services billed but not rendered. TMA should develop similar procedures to identify relationships between providers and billing agencies and identify aberrant billing patterns.

Excluding Third-Party Billing Agencies From TRICARE

TMA believed it lacks the authority to exclude billing agencies that are involved in submitting improper health care claims. Federal regulations allow TMA officials to exclude providers when it is in the best interest of the program,[11] but do not mention other entities, such as billing agencies, which provide billing services. Thus, TMA officials have only held providers accountable for the improper claims. We believe TMA should hold billing agencies accountable if they are found to be submitting improper health care claims. If TMA officials do not believe they have the authority to exclude billing agencies, they should initiate action to obtain the statutory or regulatory authority to exclude billing agencies or any entities that prepare or submit improper health care claims to the TRICARE contractors.

The GAO findings and CMS actions discussed in this report further support the need for TMA officials to strengthen controls over billing agencies. Additionally, Appendix C shows a number of criminal cases that have been successfully prosecuted that involve millions of dollars in improper claims by billing agencies, some of which bill TRICARE. By being able to identify relationships between providers and billing agencies and having the authority to exclude the latter, TMA could deny claims that are prepared by billing agencies that have abused or committed fraud against TRICARE.

Recommendations, Client Comments, and Our Response

We recommend that the Director, TRICARE Management Activity strengthen internal controls to avoid paying improper health care claims by:

1. **Identifying relationships between providers and billing agencies.**
2. **Ensuring that provider addresses are not those of billing agencies.**
3. **Initiating action to obtain the statutory or regulatory authority to sanction billing agencies or any entities that prepare or submit improper health care claims to the TRICARE contractors.**

[11] 32 C.F.R. Section 199.9.

Assistant Secretary of Defense (Health Affairs) Comments

The Assistant Secretary of Defense (Health Affairs) concurred with the report's finding that the TRICARE Management Activity needed to improve controls over payments for health care claims submitted by billing agencies. The Assistant Secretary stated that the TRICARE Management Activity will conduct a study during the next 180 days to identify specific internal control weaknesses and the best approach to strengthen those controls. The Assistant Secretary of Defense also stated that the TRICARE Management Activity will review the necessity of changing the regulatory authority to sanction billing agencies.

Our Response

The Assistant Secretary of Defense comments were responsive and conform to requirements; no additional comments are needed. However, we plan to evaluate the results of the Health Affairs study and the planned actions to ensure the intent of the recommendations is satisfied.

Appendix A. Scope and Methodology

We conducted this performance audit from January 2008 through September 2008 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our finding and conclusions based on our audit objectives.

We met with TMA personnel in Falls Church, Virginia, and Aurora, Colorado, to gather information regarding TRICARE controls over health care claims prepared by billing agencies for care provided in the United States. We met with the TRICARE North, South, and West Regional Offices. Additionally, we visited contractors and subcontractors responsible for claims processing, including TriWest, Wisconsin Physicians Services, HealthNet, Palmetto Government Benefits Administration, and Humana Military Healthcare Services, to gather information related to their roles, responsibilities, and procedures for identifying, excluding, certifying, and processing billing agency-prepared claims. We also met with Defense Criminal Investigative Service officials in Valencia and San Diego, California; CMS officials in Denver, Colorado, and San Francisco and Santa Ana, California; HHS officials via teleconference; the District Attorney's Office in San Diego, California; and the Department of Veterans Affairs officials in Denver, Colorado, to discuss their procedures or findings regarding billing agencies.

We reviewed public laws, DoD policies, and TRICARE regulations to identify the procedures and requirements established for claim submissions and reimbursements using billing agencies. Specifically, we reviewed 32 Code of Federal Regulations, Sections 199.2 through 199.9, "Civilian Health and Medical Program of the Uniformed Services;" the "Medicare Claims Processing Manual," updated January 25, 2008; 42 U.S. Code, Sections 1320a-7 and 1320c-5; and the TRICARE Systems Manual 7950.1-M and Operations Manual 6010.51-M, both dated August 1, 2002. We also reviewed supporting documentation provided by TMA officials, the TRICARE claims processing contractors, and other Federal and State entities.

TMA could not identify billing agencies; thus, we used alternative means to identify them. A private health insurance contact notified us about one billing agency potentially abusing a private health insurance program. We provided the billing agency address to TMA officials and requested that they identify payments made in FYs 2006 and 2007 to providers having that address as either their physical or billing location. That research led us to question three more addresses. We searched for the three addresses on the Internet and found that two of them belonged to other billing agencies. We requested that TMA officials research the claims database to identify payments made to the addresses of the two billing agencies. The results indicated that $2.1 million in payments were sent directly to those three billing addresses.

To identify claims prepared by HHS-excluded billing agencies, we obtained the current HHS "List of Excluded Individuals/Entities" from the Internet and matched the billing agency addresses from that list to the payment record addresses in the TRICARE Purchased Care Detail Information System. Once we determined the total dollar amounts sent to those addresses, we sorted the data by official exclusion date to determine the number of claims and dollars paid, in error, to each excluded billing agency after the official exclusion date.

Finally, by querying TRICARE claims data for providers that listed one of the three known billing agency addresses as their own billing address, we identified 186 providers that had the same billing address as the billing agency; 93 of which had the same provider address as the billing agency.

We could not identify potentially fraudulent billing patterns because TMA did not identify billing agencies. However, we identified improper claims submitted for a provider that used one of these billing agencies, and we issued a criminal referral to the Defense Criminal Investigative Service regarding these improper claims.

Use of Computer-Processed Data

We used computer-processed data to identify payments sent to three billing agencies and payments sent for claims prepared by three HHS-excluded billing agencies. We did not perform a formal reliability assessment of the computer-processed data for this project. However, our work on two prior reports (listed below) showed that data from the TRICARE Purchased Care Detail Information System were generally accurate and sufficient to support the conclusions from the two reports. We did not use these data to make any statistical projections, nor did we attempt to determine materiality on the claims referenced.

Prior Coverage

During the last 10 years, the Government Accountability Office (GAO), DoD Inspector General (DoD IG), and Health and Human Services Office of Inspector General (HHS OIG) have issued eight reports discussing controls over billing agencies. Unrestricted GAO reports can be accessed at www.gao.gov. Unrestricted DoD IG reports can be accessed at http://www.dodig.mil/audit/reports. Unrestricted HHS IG reports can be accessed at www.oig.hhs.gov/reports.html.

GAO

GAO Report No. T-OSI-00-15, "Schemes to Defraud Medicare, Medicaid, and Private Health Care Insurers," July 25, 2000

GAO Report No. T-HEHS-00-93, "Concerns About HCFA's Efforts to Prevent Fraud by Third-Party Billers," April 6, 2000

GAO Report No. OSI-00-5R, "Improper Third-Party Billing of Medicare by Behavioral Medical Systems, Inc.," March 30, 2000

GAO Report No. OSI-00-1R, "Fraud Schemes Committed by Career Criminals and Organized Criminal Groups and Impact on Consumers and Legitimate Health Care Providers," October 5, 1999

GAO Report No. HEHS 99-127R, "Identifying Third-Party Billing Companies Submitting Claims," June 2, 1999

DoD IG

DoD IG Report No. D-2008-045, "Controls Over the TRICARE Overseas Healthcare Program," February 7, 2008

DoD IG Report No. D-2006-051, "TRICARE Overseas Controls Over Third Party Billing Agencies and Supplemental Insurance Plans," February 10, 2006

HHS OIG

HHS Report No. OEI-05-99-00100, "Medical Billing Software and Processes Used to Prepare Claims," March 2000

Appendix B. CMS Form 855, "Medicare Enrollment Application," Section 8, "Billing Agency Information"

SECTION 8: BILLING AGENCY INFORMATION

Applicants that use a billing agency must complete this section. A billing agency is a company or individual that you contract with to process and submit your claims. If you use a billing agency, you are responsible for the claims submitted on your behalf.

❑ **Check here if this section does not apply and skip to Section 12.**

BILLING AGENCY NAME AND ADDRESS

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	❑ CHANGE	❑ ADD	❑ DELETE
DATE (mm/dd/yyyy)			

Legal Business/Individual Name as Reported to the Social Security Administration or Internal Revenue Service

Tax Identification Number or Social Security Number *(required)*

"Doing Business As" Name *(if applicable)*

Billing Agency Address Line 1 *(Street Name and Number)*

Billing Agency Address Line 2 *(Suite, Room, etc.)*

City/Town		State	ZIP Code + 4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*	

SECTION 9: FOR FUTURE USE (This Section Not Applicable)

SECTION 10: FOR FUTURE USE (This Section Not Applicable)

SECTION 11: FOR FUTURE USE (This Section Not Applicable)

Appendix C. Several Cases of Billing Agency Irregularities

Billing Agency	Irregularity
Handle With Care, Inc.	This billing agency was identified in the early 1990s from a criminal investigation as billing Medicare for surgical dressings amounting to $7.4 million for surgeries that never occurred.
Professional Medical Billers	From 1994 to 1996, the billing agency fabricated services on providers' claims and submitted the claims to Federal health care programs using the providers' ID numbers. The billing agency reimbursed the providers for legitimate charges and kept the overpayments.
Emergency Physician Billing Service	In 1999, the billing agency was sentenced for increasing client reimbursement 10 percent to 25 percent by upcoding or filing claims for a higher level of service than was actually delivered. This involved the Federal health care programs, including TRICARE. The billing agency received payment based on a percentage of the revenues billed or recovered, depending on the client.
Behavioral Medical Systems	In 2000, the GAO reported that this billing agency submitted claims to Medicare for services not rendered, which totaled $1.3 million.
Medaphis	In 1998, a whistleblower reported that this billing agency submitted duplicate claims with incorrect charges on behalf of its client.
Gottlieb Financial Services, Inc.	This billing agency used a software system that upcoded emergency room visits, resulting in a $15 million settlement in 1999.
Health Visions Corporation	In 2006, DoD IG identified wide-scale medical billing improprieties in the Philippines by a billing agency. The company billed and received payments from TRICARE directly, without the provider certifying that services were performed and accurately billed, allowing it to inflate charges. The United States Attorney's Office estimated billing improprieties of about $100 million.
All-Med Billing Corporation	In 2007, a federal grand jury issued a 46-count indictment against the billing agency for submitting about $80 million in false claims to Medicare on behalf of 29 durable medical equipment companies.
R and I Medical Billing, Inc.	In 2007, the billing agency was identified as submitting claims to Medicare for infusions, totaling $170 million. It received about 5 percent of each reimbursement.

Assistant Secretary of Defense (Health Affairs) Comments

THE ASSISTANT SECRETARY OF DEFENSE
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HEALTH AFFAIRS

DEC 1 2008

MEMORANDUM FOR DEPARTMENT OF DEFENSE INSPECTOR GENERAL
DEPUTY INSPECTOR GENERAL FOR AUDITING
DIRECTOR, MILITARY HEALTH SYSTEM DIVISION

SUBJECT: Draft Report, "TRICARE Controls Over Claims Submitted by Third Party Billing Agencies"—Project Number D2008-D000LF-0100.00

Thank you for the opportunity to review and provide comments on the draft report, "TRICARE Controls Over Claims Submitted by Third Party Billing Agencies" (D2008-D000LF-0100.000).

I concur with the report's conclusion that TRICARE Management Activity (TMA) needs to improve controls over payments for health care claims submitted by billing agencies. I also agree with the Department of Defense Inspector General's assessment of the difficulty of "linking providers to problematic billing agencies." As a result, to assess what actions are required to strengthen internal controls over payments to third party billing agencies, TMA will conduct a review during the next 180 days.

My specific comments to the draft report findings and recommendations are attached. Please feel free to direct any questions on this audit to Mr. Kenneth Jacobs (Functional) at (303) 676-3568 or Mr. Gunther J. Zimmerman (Audit Liaison) at (703) 681-4360.

S. Ward Casscells, MD

Attachment:
As stated

DoD IG DRAFT REPORT
D2008-D000LF-0100.00

"TRICARE Controls Over Claims Submitted by Third-Party Billing Agencies"

TRICARE MANAGEMENT ACTIVITY COMMENTS

RECOMMENDATIONS:
TRICARE recommends that the Director, TMA strengthen internal controls to avoid payment improper health care claims by:

1. Identifying relationships between providers and billing agencies.

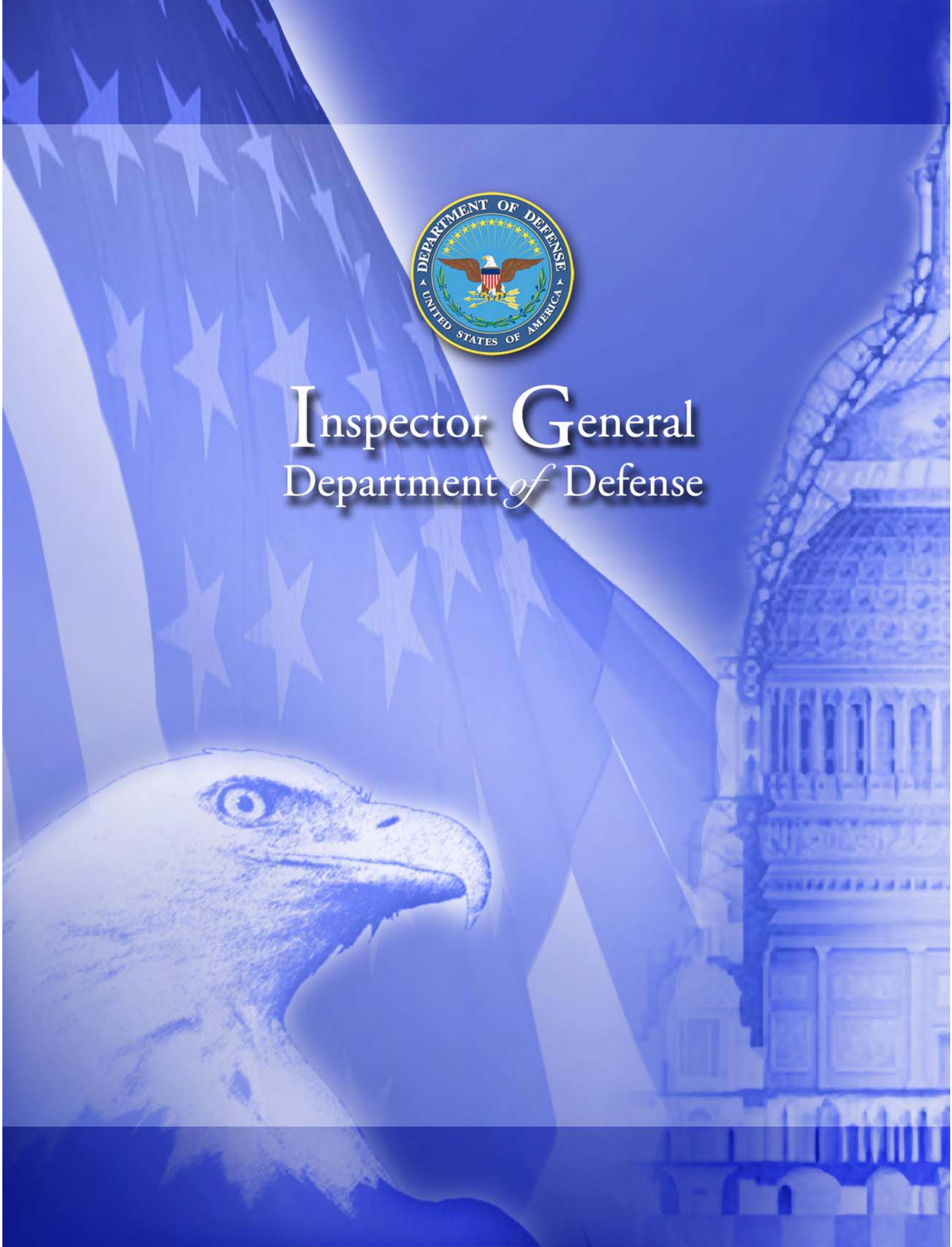
2. Ensuring that provider addresses are not those of billing agencies.

3. Initiating action to obtain the statutory or regulatory authority to sanction billings agencies or any entities that prepare or submit improper health care claims to the TRICARE contractors.

TMA RESPONSE:
Recommendation 1 – The agency will study the internal controls currently in place to determine specific weaknesses as they relate to third party billing agencies and will identify processes required to strengthen those areas. TRICARE anticipates this study to be completed no later than 180 days from the date of this response.

Recommendation 2 – Upon completion of the study referenced above, the agency will determine the best approach to take to strengthen our internal controls over payments made to third party billing agencies.

Recommendation 3 – The agency will review this recommendation to determine the necessity of changing the regulatory authority to sanction billing agencies. TRICARE anticipates this review to be completed no later than 180 days from the date of this response.


Inspector General
Department of Defense